

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2015
NAME OF PROVIDER OR SUPPLIER BRYAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2150 EAST MCCORD, PO BOX 568 CENTRALIA, IL 62801		
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Z9999	<p>FINDINGS</p> <p>STATEMENT OF LICENSURE VIOLATIONS:</p> <p>350.620a) 350.1210 350.1220j) 350.1230b)3)7) 350.1230c) 350.1230d)1)2) 350.1240b)1) 350.1610g) 350.1620d)3) 350.3240a)</p> <p>Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.</p> <p>Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health.</p> <p>Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus</p>	Z9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/11/15

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STREET ADDRESS, CITY, STATE, ZIP CODE

BRYAN MANOR

**2150 EAST MCCORD, PO BOX 568
CENTRALIA, IL 62801**

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Z9999	<p>Continued From page 1</p> <p>ulcers or a weight loss or gain of five percent or more within a period of 30 days.</p> <p>Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents.</p> <p>Section 350.1240 Dental Services b) There shall be comprehensive treatment services for all residents which include, but are not limited to, the following: 1) Provision for dental treatment.</p> <p>Section 350.1610 Resident Record Requirements g) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output.</p>	Z9999		

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Z9999	<p>Continued From page 2</p> <p>Section 350.1620 Content of Medical Records d) In addition to the information that is specified above, each resident's medical record shall contain the following: 3) Nurse's notes that describe the nursing care provided, observations and assessment of symptoms, reactions to treatments and medications, progression toward or regression from each resident's established goals, and changes in the resident's physical or emotional condition.</p> <p>Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to provide clients with nursing services in accordance with their needs when facility failed to:</p> <p>1) a) thoroughly investigate the death of 1 of 1 (R23) individual who had a routine gastric tube change on 10/12/15. R23 was transferred to the hospital on 10/14/15 for complaints of abdominal pain and hypoactive bowel sounds. During the course of the emergency room visit a CT (computerized tomography) scan found that the gastric tube was in an extragastric location. The facility investigation did not identify nursing staff's failure to follow policy and procedure for checking R23's gastric tube for placement. The facility investigation noted the gastric tube had been changed on 10/13/15 and R23's Medication Administration Record documents the gastric tube was changed on 10/12/15. There is no corrective action documented on the facility</p>	Z9999		

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Z9999	<p>Continued From page 3</p> <p>investigation related to R23's gastric tube,</p> <p>b) identify nursing staff's failure to follow facility policy and procedure for checking R23's gastric tube placement prior to administration of medications and enteral feedings,</p> <p>c) train/re-train staff on checking gastric tube placement prior to administration of medications/enteral feedings and thorough documentation. These failures have the potential to put 51 (R3, R6,R7, R8, R9, R18, R20, R21, R22, R24-R65) individuals who have gastric tubes in place and currently reside at the facility at risk of harm.</p> <p>2) ensure nursing staff follow the facility policy of checking for gastric enteral tube placement prior to the administration of medications and enteral nutrition for 1 of 1 (R22) individual who was observed during medication administration to not have placement of the gastric tube verified by the two step procedure,</p> <p>3) assess and document changes for 2 of 2 (R17 and R24) individuals outside the sample with open areas/pressure ulcers that were acquired at the facility,</p> <p>4) ensure staff follow facility policies and procedures for repositioning 2 of 2 (R7 and R17) individuals who have a history of and/or current open areas per the individuals plan,</p> <p>5) follow prescribed dental hygiene methods for individuals with hemophiliac conditions for 1 of 1 (R7) individual in the sample who is identified as being hemophiliac.</p>	Z9999		

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Z9999	<p>Continued From page 4</p> <p>Findings Include:</p> <p>1) Review of the facility Health Passport dated 11/10/15 documents R23 is a 71 year old male who functions at a Profound Level of Intellectual Disability.</p> <p>Review of the facility "G-tube (insertion/removal/placement) policy" dated 11/14/11 documents, "Placement should be checked at least once a shift when the tube is not in use. Also check the tube prior to feeding, flushes, and meds. Also check tube placement if there is any question that the tube may not be in the correct place, or if there has been an incident involving the tube being pulled."</p> <p>Review of the facility policy "Enteral Medication Administration" (not dated) documents; "Check tube for placement by: A. Inserting 60 cc (cubic centimeters) syringe filled with 10-20 cc air into the G-tube. Place a stethoscope over the stomach, insert 10-20 cc of air and assess for the air sound in the stomach as the air is instilled into the tube. B. Then gently pull back the plunger of the syringe to gently aspirate residual. Once residual is noted, gently apply pressure to the plunger to reinsert residual into the G-tube. C. If residual is not obtained and the G-tube stoma site is over 6 weeks old and air auscultation was heard, proper placement has been verified and continue. D. If residual is not obtained and the G-tube stoma site is not over 6 weeks old, call physician to obtain an order for x-ray to verify placement. E. Document on nursing assessment flow sheet that proper placement was verified."</p> <p>Review of R23's Medication Administration Record dated 10/2015 documents an order to change the gastric enteral tube every three</p>	Z9999			

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Z9999	<p>Continued From page 8</p> <p>tube. There was no tube visible through the scope. I desufflated the old Gtube balloon and removed the tube..."</p> <p>Review of the CT scan abdomen and pelvis dated 10/21/15 documents; "History: Malfunction of gastrostomy tube. Findings: The patient apparently had a G tube misplaced 10/14/15. That G tube had been pulled down through the stomach and a pseudotract out to the skin, that is available on the injection from October 14, 2015...."</p> <p>Review of the facility Nursing Services Case Review (death investigation) dated 11/02/15 documents;</p> <p>"Description of Medical Services during previous 60 days: "R23 saw his primary care physician here at the facility for a routine check up with no new orders either time. R23 had constipation but was relieved with bowel aids as ordered by physician. On 10/13/15 Routine G (gastric enteral) tube change completed by E13 (Licensed Practical Nurse) and placement verified x (times) 3. On 10/14/15 (name of physician) was notified due to abdomen tender and hypoactive bowel sounds. While in the ER (emergency room) CT (computerized tomography) done of abdomen and extragastric location of the G- tube was noted. A consult was then scheduled with (name of physician) per (name of hospital) records. R23 expired on 10/27/15 and cause of death was septic shock, pneumonia, and peritonitis."</p> <p>Areas of concern; omissions in delivery of services: "blood pressures (sic) taken prior to medication administration.</p> <p>Recommendations based on QA (Quality</p>	Z9999			

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Z9999	<p>Continued From page 9</p> <p>Assurance) "In-service nursing staff on following physician orders since the blood pressure documentation was missing and the orders state to obtain it prior to administration of the metoprolol tartrate."</p> <p>This case review dated 11/02/15 does not document any findings related to feeding tube placement.</p> <p>During interview on 11/10/15 at 12:30 PM E9 (Assistant Director of Nursing) stated, R23 would receive enteral nutrition via the gastric enteral tube from 6:00 AM to 7:00 PM daily and medications at 10:00 AM and 10:00 PM. E9 confirmed placement of the tube should be checked prior to the administration of medications and beginning the enteral nutrition. E9 stated R32 was sent to the hospital on 10/14/15 after the nurse spoke with the physician at 8:10 AM for evaluation of abdominal distention and hypoactive bowel sounds. E9 confirmed the nursing staff did not document checking placement of the gastric enteral tube prior to administering medications at 10:00 AM on 10/13/15 and prior to the 50 cc's of fluid that was administered on 10/14/15 between 6:00 AM and 7:00 AM. E9 stated those placement checks should have been documented as well as if the enteral nutrition was started on 10/14/15 at 7:00 AM as ordered. When asked if the death review noted the information related to placement checks not being documented, E9 stated, "No." When asked if the staff had been trained/re-trained after the death review E9 stated, " Not that I am aware of. The staff were trained on blood pressures but nothing on the feeding tubes."</p> <p>During interview on 11/16/15 at 11:02 AM E2 (Director of Nursing) stated the staff had not</p>	Z9999		

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Z9999	<p>Continued From page 10</p> <p>trained on documentation or checking placement of the gastric enteral tubes after the death review. E2 confirmed R23's routine gastric tube change occurred on 10/12/15. When asked if the death review was complete E2 stated, "Yes." When asked if it included findings related to R23's gastric enteral tube, E2 stated, "I should have caught that."</p> <p>During interview on 11/18/15 at 12:31 PM when asked if the gastric tube being out of place was the cause of death, Z2 stated, "The PEG tube site was infected/inflamed....The PEG tube was in place but had infection and inflammation around it because the hole was wider allowing the feeding to come out because of looseness of tube." Z2 was not able to confirm the actual cause of death.</p> <p>2. The facility 'Functional Levels', dated 11/03/15, identifies R22 as an individual who functions in the Profound level Intellectual Disabilities and received medication via a gastric enteral tube.</p> <p>On 11/04/14 during the 9 AM scheduled medication administration, E3 (Registered Nurse) did not fully check placement. E3 only inserted 10-20cc of air into the gastric tube to listened for the air sounds only. E3 did not check for residual prior to administering the following medications to R22 thru his gastric enteral tube: Ferrous Sulfate 220 mg (milligram), Finasteride 5 mg, Folic Acid 20 mg, Furosemide 20 mg, Levetiracetam 7.5 ml (milliliter), Levothyroxine 50 mcg (micrograms), Lisinopril 2.5 mg, Metformin 500 mg, Metoprolol Tartrate 25 mg,</p>	Z9999		

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Z9999	<p>Continued From page 12</p> <p>"Nurses shall provide nursing services in accordance with the individual's needs which shall include a plan to maintain skin integrity and a modification of this plan as needed.</p> <p>1. When a DSP (Direct Support Person) notices a red area, bruise, abrasion, or suspected change in the condition of an individual's skin, the nurse must be notified as soon as possible. The DSP is responsible to note this change on the wing assignment sheet at the time of discovery, or at least prior to the end of the shift, documenting that the area of concern was reported to the wing nurse.</p> <p>2. If an issue is reported to the Nurse, or the Nurse notices a red area, bruise, abrasion, blister, etc. he/she will evaluate the condition, make a detailed Nursing (Note)/ T Log (electronic charting) in the electronic chart, notify the Shift Supervisor. For areas identified as compromised skin integrity, or potential risks to skin integrity, the Nurse contact the Shift Supervisor, and together they will decide upon a Care Plan related to the Skin Integrity/ Non- pressure/ Pressure area/ Wound. The Nurse and Supervisor will utilize the Care Plan Template to (ensure) that all appropriate approaches are identified and implemented.</p> <p>3. The nurse will implement a new Skin / Wound plan in the Health Tracking Section of Therap/ E-chart.</p> <p>4. The nurse will be responsible to determine if the physician must be contacted to obtain a course of action and document in the t-log. The nurse will also be responsible to contact the guardian regarding the change in status and the IDPH (Illinois Department of Public Health) if the</p>	Z9999			

Illinois Department of Public Health

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NAME OF PROVIDER OR SUPPLIER BRYAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2150 EAST MCCORD, PO BOX 568 CENTRALIA, IL 62801		
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Z9999	<p>Continued From page 13</p> <p>wound is related to pressure or requires outside services. The nurse will send out an s-comm (notice) to the custom user group "wound" with wound in the subject line.</p> <p>5. Once an area is identified that requires a change in routine treatment and care, the attending nurse will add "daily skin assessment" on the MAR (Medication Administration Record) in addition to any specific treatment ordered by the physician. Each day the attending nurse shall be responsible to assess the condition of the skin, and complete the Skin Integrity Care Plan. The MAR will also designate the day the weekly measurements are obtained; which will be added on the detail mode. Nurses should be including any pertinent information regarding the condition, healing, problems, to the comment section of the care plan, as well as specific information regarding the exact location of the compromised skin on the body.</p> <p>6. The Care Plan Coordinator will be responsible to update the care plan once a change in the plan has been determined by the attending nurse and supervisor. She shall also be responsible to review the Skin Integrity Programs on a weekly basis and spot check the status of the area/ wound on at least a weekly basis. She will also be responsible to add a note on the care plan of her assessment and the efficacy of the treatment plan."</p> <p>a) Emergency Data Form (dated 10/30/15) identifies R24 as a 43 year old individual who functions at the profound level of intellectual disability with additional diagnoses of Spastic Quadriplegia and Cerebral Palsy. The data form also states R24 is nonverbal, non-weight bearing, non-ambulatory and receives nutrition per</p>	Z9999			

Illinois Department of Public Health

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Z9999	<p>Continued From page 14</p> <p>a gastrostomy tube.</p> <p>Wing Assignment Sheet (dated 10/16/15 6:00 AM- 6:30 PM) under section titled Reported Concerns documents, "Reported to nurse (E12/ Licensed Practical Nurse) that R24 has 2 spots on her toes (last 2 left foot). Intact dried up blister. (left open to air)."</p> <p>In Review of T-Log Search (electronic documentation/ dated 10/16/15- 11/5/15) There was no documentation by nursing of the altered skin integrity to toes reported by direct care staff on 10/16/15. There was no written evidence nursing assessed the compromised skin integrity to the toes on the left foot daily from 10/16/15- 10/23/15. The T- Log dated 10/24/15 documents, "Client noted to have pressure areas on left 4th and 5th toes. Left toe measures 1.4 cm length by 1 cm width with open peeling skin, no signs or symptoms of infection and only top layer of skin off, no open sore or wound to site. Left 5th toe is blackened, soft and unstageable. Measures 2.5 cm length by 2 cm width, unknown depth. Area not open but very soft." There was no evidence nursing followed the facility's Skin Integrity Policy in regards to initiating a Skin/ Wound Care Plan until after the areas to the 5th toe developed blackened (eschar) tissue. The T- Log documents R24 went to the wound clinic on 11/2/15 to have the the 5th toe debrided.</p> <p>ISP Data Search (nursing wound assessments/ dated 10/25/15- 11/13/15) does not have evidence of nursing documenting daily assessments of R24's open wounds to toes on left foot for 10/27/15, 10/28/15, 10/30/15, 11/1/15- 11/5/15, 11/7/15, 11/8/15, 11/11/15 and 11/12/15.</p> <p>Medication Administration Record print out has</p>	Z9999		

Illinois Department of Public Health

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BRYAN MANOR

**2150 EAST MCCORD, PO BOX 568
CENTRALIA, IL 62801**

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Z9999	<p>Continued From page 15</p> <p>documentation of weekly wound measurements of R24's left toes for 11/2/15. There was no weekly measurement made for 11/9/15.</p> <p>In interviews with E2/ Director of Nursing on 11/16/15 at 11:05 AM and 11:45 AM, E2 confirmed R24 is a full assist with all activities of daily living including bathing. E2 reported to surveyor the work shop reported a skin integrity issue with R24's toes to left foot on 10/16/15. E2 confirmed nursing should have initiated the Skin Integrity Policy when direct support staff reported the 2 spots to R24's toes on 10/16/15. E2 confirmed nursing did not initiate the facility's Skin Integrity Policy until after R24's toe developed black eschar. E2 confirmed nursing did not document daily wound assessments as per facility policy for R24.</p> <p>b) Review of the facility resident roster (not dated) documents R17 is a 59 year old individual who functions at a Profound Level of Intellectual Disability.</p> <p>During observation on 11/04/15 beginning at 2:05 PM R17 was observed in bed. E22, E23, and E24 (Direct Support Person) were present at the time of the observation. R17 was observed to have a stage 2 area to her right buttock. The skin surrounding the open area was red, pink, and white in color and appeared to be scar tissue. There was no drainage or other obvious symptoms of infection.</p> <p>Review of the T- Log (nursing documentation) for R17 documents; "10/26/15 10:00 AM KWI (workshop) informed this nurse of open area. upon assessment 1cm x1cm (centimeter) open area on right buttock. prn zinc oxide was applied per this nurse. floor</p>	Z9999		

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Z9999	Continued From page 16 supervisor notified. skin assessment started. 10/28/15 zinc oxide applied to OA (open area) on Rt (right) buttock. 10/28/15 N.O. (new order) received tx. (treatment) for open area to buttocks apply skin prep and ploymem q (every) 3 days and PRN (as needed) for 15 days. 10/29/15 Polymem to Rt. (right) buttock, changed due to soiling. Tolerated well. 11/03/15 Dressing dry and intact to buttocks. No discomfort noted. Monitoring 11/03/15 Area to right buttocks healing well, dressing as ordered and following altered up time schedule. 11/04/15 dressing dry and intact to buttocks. No discomfort noted. Monitoring 11/05/15 Dressing to buttocks dry/intact. No discomfort noted. Monitoring." 11/07/15 Dressing dry and intact to buttocks. No discomfort noted. Monitoring 11/08/15 No dressing to buttocks upon assessment. area not open. red/purple in color. new polymem applied after skin prep. tolerated well." Review of the ISP Data Collection for R17 documents; "10/28/15 No exudate, No odor, Wound bed pink, .125x.125, eschar noted to outer each of wound bed 10/30/15 No exudate, No odor, wound bed not changed, continue treatment 11/01/15 No exudate, No odor, wound bed not changed, continue treatment 11/07/15 No exudate, No odor, wound bed: are red/purple not open 11/08/15 No exudate, no odor, wound bed: no dressing on buttocks area closed but still very red/purple in color	Z9999		

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Z9999	<p>Continued From page 17</p> <p>11/09/15 healed"</p> <p>During interview on 11/09/15 at 3:40 PM E9 (Assistant Director of Nurses stated, there was no nursing documentation showing measurements had been taken of the open area between 10/28/15 and 11/09/15.</p> <p>During interview on 11/10/15 at 11:55 AM E9 (Assistant Director of Nurses) stated, R17's open area was acquired at the facility. "R17 has scar tissue on the right buttock. It (skin breakdown) started out looking like shearing."</p> <p>4) a) Review of the facility resident roster (not dated) documents R7 is a 39 year old individual who functions at a Profound Level of Intellectual Disability.</p> <p>During observation on 11/03/15 beginning at 2:00 PM and ending at 4:45 PM R7 was observed in bed.</p> <p>Review of R7's positioning sheets documents;</p> <p>10/29/15 6 AM to 6:30 PM: R7 was not repositioned from 7:10 to 10:00 (2 hours and 50 minutes) and from 11:00 to 3:35 (4 hours and 35 minutes),</p> <p>10/31/15 6:00 AM to 6:30 PM: R7 was not repositioned from 9:20 to 12:25 (3 hours and 5 minutes), R17 was not repositioned from 4:00 to 10:00 (6 hours)</p> <p>10/31/15 6:00 PM to 6:30 AM: R7 was not repositioned from 3:06 to 5:45 (2 hours and 39 minutes),</p> <p>11/01/15 6:00 AM to 6:30 PM: R7 was not repositioned from 9:30 to 12:15 (2 hours and 45 minutes),</p> <p>11/01/15 6:00 PM to 6:30 AM: R7 was not</p>	Z9999		

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NAME OF PROVIDER OR SUPPLIER

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Z9999	<p>Continued From page 18</p> <p>repositioned from 3:32 to 5:50 (2 hours and 15 minutes), 11/02/15 6:00 PM to 6:30 AM: R7 was not repositioned from 9:40 to 12:40 (3 hours), 11/03/15 6:00 PM to 6:30 AM: R7 was not repositioned from 2:57 to 5:40 (2 hours and 43 minutes).</p> <p>b) Review of the facility resident roster (not dated) documents R17 is a 59 year old individual who functions at a Profound Level of Intellectual Disability.</p> <p>Review of R17's T Log (nurses notes) dated 10/26/15 documents, "10:00 AM KWI(workshop) informed nurse of open area. Upon assessment 1 cm (centimeter) x 1 cm open area on right buttock.</p> <p>Review of R17's positioning sheets documents;</p> <p>10/28/15 6 AM to 6:30 PM: R17 was not repositioned from 6:50 to 10:25 (3 hours and 35 minutes) and from 1:30 to 5:10 (3 hours and 40 minutes), 10/29/15 6 AM to 6:30 PM: R17 was not repositioned from 9:50 to 12:15 (2 hours and 25 minutes) and from 1:30 to 5:10 (3 hours and 40 minutes), 10/29/15 6:00 PM to 6:30 AM: R17 was not repositioned from 8:50 to 12:33 (3 hours and 43 minutes) and from 3:45 to 7:00 (3 hours and 15 minutes), 10/30/15 6:00 AM to 6:30 PM: R17 was not repositioned from 12:50 to 4:00 (3 hours and 10 minutes), 10/30/15 6:00 PM to 6:30 AM: R17 was not repositioned from 1:15 to 4:47 (3 hours and 30 minutes),</p>	Z9999		

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Z9999	<p>Continued From page 19</p> <p>10/31/15 6 PM to 6:30 AM: R17 was not repositioned from 9:32 to 12:45 (3 hours and 13 minutes) and from 3:21 to 5:40 (2 hours and 20 minutes),</p> <p>11/02/15 6:00 AM to 6:30 PM: R17 was not repositioned from 1:50 to 5:15 (3 hours and 25 minutes),</p> <p>During interview on 11/10/15 at 10:30 AM E9 (Assistant Nursing Director) stated if the individuals who reside at the facility are not on an alternate turn and reposition schedule, then they are to be turned and repositioned every two hours. E9 confirmed R7 and R17 should have been turned and repositioned every two hours. When asked if there was any other place the staff would document turning and repositioning E9 stated, "No." E9 reviewed the positioning sheets for R7 and R17 and confirmed the documentation does not identify R7 and R17 were turned and repositioned per the facility policy.</p> <p>During interview on 11/10/15 at 11:50 AM E8 (Training Coordinator) confirmed the facility did not have reproducible evidence R7 and R17 were turned and repositioned as scheduled.</p> <p>5) Medication Administration Record/ MARS (dated 11/1/15- 11/30/15/ reviewed by surveyor on 11/10/15 at 11:15 AM) identifies R7 as a 39 year old individual who functions at the profound level of intellectual disability with additional diagnosis of Hemophilia. The MARS documents under Dental Care, "Nursing to brush teeth with electric tooth brush after breakfast and before bedtime and PRN. (as needed)" There is documentation that E3/ Registered Nurse provided dental hygiene 5 times from 11/1/15-11/10/15 for R7, including an entry for 11/10/15 at 10:00 AM.</p>	Z9999			

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Z9999	Continued From page 20 Appointments (dated 7/15/15) documents R7 was provided services onsite by Z1/ Registered Dental Hygienist. The consultation documents, "Hygienist here teeth scaled resident did very well, heavy plaque and calculus. Bleeds easily. (Follow up) as scheduled." Dental Consultation (dated 8/28/15) documents, "Exam- Already heavy buildup/ (moderate) perio-needs cleaned; no (pathology symptoms) noted." In an interview with E3/ Registered Nurse on 11/10/15 at 11:15 PM, when surveyor asked who brushes R7's teeth, E3 stated, "We do." E3 confirmed nurses brush R7's teeth due to his diagnosis of Hemophilia. When asked how and when R7's teeth are brushed, E3 stated, "We use mouth wash and suction tooth brush once a shift." When surveyor requested E3 to show the tooth brush used for R7, E3 took surveyor to R7's room, went to the wall where the suction machine was and stated, "They must have thrown his toothbrush away, I will have to get him a new one." E3 then showed surveyor a suction tooth brush used by R7's room mate. As surveyor and E3 left R7's room, E3 stated, "I still need to brush his teeth." Surveyor went to check documentation on the electronic medication administration record and found E3 had already documented R7's teeth had been brushed." In a later interview on 11/10/15 at 12:00 PM with E3, E3 stated, "R7 has an electric tooth brush (battery operated). I just brushed his teeth." E3 confirmed she had not brushed R7's teeth until after surveyor had interviewed her at 11:15 AM. E3 confirmed R7 does not use suction tooth brush but an electric (battery operated) tooth	Z9999		

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Z9999	Continued From page 21 brush. E3 confirmed she has been his nurse prior to today. Observation on 11/10/15 at 12:05 PM, E3 showed surveyor a battery operated tooth brush found in a plastic case in a dresser drawer in R7's room. (A)	Z9999			

Attachment B

Imposed Plan of Correction

Page 1 of 2

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: BRYAN MANOR

DATE AND TYPE OF SURVEY: November 24, 2015 Annual Health Survey, First follow-up to 9/17/2015 survey.

350.620a)
350.1210
350.1220j)
350.1230b)3)7)
350.1230c)
350.1230d)1)2)
350.1610g)
350.1620d)3)
350.3240a)

The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

The facility shall provide all services necessary to maintain each resident in good physical health.

The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.

Residents shall be provided with nursing services, in accordance with their needs.

Periodic reevaluation of the type, extent, and quality of services and programming.

A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel.

Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output.

Nurse's notes that describe the nursing care provided, observations and assessment of symptoms, reactions to treatments and medications, progression toward or regression from each resident's established goals, and changes in the resident's physical or emotional condition.

An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

This will be accomplished by:

- I. The Administrator, Director of Nurses, and nursing staff will be trained, by Mandatory in-service, in the facility's policies and procedures concerning Skin Integrity, Enteral Medication Administration; Using the Medication Administration Record; and Administering Medication and Treatments according to the Physician's Order. Policies Relating to providing nursing care according to the individual's needs, detecting signs of illness, dysfunction or maladaptive behavior that warrant nursing intervention, and

subsequent follow-up with proper documentation to insure the health and safety of each individual.

- II. The facility will provide all services necessary to maintain each resident in good physical health.
- III. Direct care personnel will be trained in, basic skills required to meet the health needs and problems of the residents.
- IV. The facility shall notify the resident's physician of any accident, injury or change in the resident's condition that threatens the health safety or welfare of the individual.
- V. The Director of Nursing or her designee shall be responsible to participate in biweekly, or as needed reviews of the individual's services and programming.
- VI. The Administrator shall be responsible to insure that all staff are trained in the policies and procedures and can demonstrate competence to identify and report mistreatment, abuse and neglect.
- VII. The Administrator and Director of Nurses will monitor Items I through VI listed above to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: TEN (10) days from receipt of this Imposed Plan of Correction.

LJK:12-29-2015

Attachment B
Imposed Plan of Correction